# IDAHO RYAN WHITE MEDICAL CASE MANAGEMENT
# INTAKE AND ELIGIBILITY DETERMINATION

**Date of Intake/Eligibility Initiated**
**_____/_____/_____**

*Client URN:* _____ *ADAP ID:* _____

**PERSONAL/CONTACT INFORMATION**

| | | |
|---|---|---|
| **Legal Last Name:** | **Legal First Name:** | **MI:** |
| **Preferred Name:** | **Social Security Number:** | |
| **Date of Birth:** _____/_____/_____ | **Gender**: □ Male □ Female □ Transgender □ Refused to Report □ Unknown | |
| **Address:** | **City:** | |
| **County:** | **State:** | **Zip Code:** |

**Mailing address if different from above:**

**Phone (H)** (____) _____-_____ **(W)** (____) _____-_____ **Cell/Pager** (____) _____-_____

**Emergency Contact/ Legal Guardian:** _____ **Phone** (____) _____-_____
**Aware of HIV+ Status: □ Y □ N**

**Client Preference for Contact:** □ phone □ phone message □ office visit
□ home visit □ mail □ email (_____)

May talk to: 1) _____ 2) _____

Are there any concerns related to the above contacts? If yes, please explain.

**Preferred Language:** _____ **Interpreter Needed? □ YES □ NO**

**Ethnicity:** □ Non-Hispanic □ Hispanic

**Hispanic Subgroup: (Only select if you Hispanic Ethnicity was marked)**
□ Mexican, Mexican American, Chicano/a □ Puerto Rican
□ Cuban □ Another Hispanic, Latino/a or Spanish origin

**Race (may mark more than one):**
□ White
□ Black or African American
□ Asian
□ American Indian or Alaska Native
□ Native Hawaiian or Other Pacific Islander

**Asian Subgroup: (only select if Asian was marked)**
□ Asian Indian □ Chinese □ Filipino □ Japanese
□ Korean □ Vietnamese □ Other Asian

**Native Hawaiian or Other Pacific Islander Subgroup: (only select if Native Hawaiian or Other Pacific Islander was marked)**
□ Native Hawaiian □ Guamanian or Chamorro □ Samoan
□ Other Pacific Islander

**Relationship Status:** □ Single □ Married □ Partner □ Divorced □ Separated □ Widow

**Occupation:** _____ **Employer:** _____
**Status of Employment:** □ None □ Retired □ Employed □ Unemployed

**Veteran Status:** □ Veteran □ Disabled veteran □ Non-veteran

## HIV STATUS

**Proof of HIV Diagnosis?** □ Yes □ No
**Date of Original HIV Diagnosis (**□ Self-Report □ Medical Records**)** _____/_____/_____ (□ Estimated)
**State where diagnosed: _____** **Original CD4 count: _____**

**AIDS Diagnosis?** □ Yes □ No
**Date of Original HIV Diagnosis (**□ Self-Report □ Medical Records**)** _____/_____/_____ (□ Estimated)
**Year first accessed care: _____** **Original CD4 count at AIDS diagnosis: _____**

**HIV Status:**
□ HIV Positive (not AIDS) □ HIV Negative (affected)
□ HIV Positive (AIDS status unknown) □ HIV Indeterminate (0-2 years)
□ CDC-Defined AIDS □ Unknown

**Is client currently prescribed ARVs?**
□ Yes □ No

**Risk Factor (check all that apply):**
□ MSM □ IDU □ Hemophilia/Coagulation Disorder □ Heterosexual Contact
□ Receipt of transfusion blood, blood components or tissue □ Mother with/at Risk for HIV
□ Not Reported or Not Identified

**Initial Idaho Ryan White Lab:**
Current CD4 count: _____ Date of test: _____/_____/_____
Current Viral Load: _____ Date of test: _____/_____/_____

**HIV Care Provider:**
Name: _____ Phone: (____) _____-_____
Clinic Name: _____
Address: _____

**Primary Care Provider:**
Name: _____ Phone: (____) _____-_____
Clinic Name: _____
Address: _____

**Primary Pharmacy:**
Name: _____ Phone: (____) _____-_____
Address: _____

**CLIENT REFERED BY (NO INDIVIUAL NAMES): _____**

**CLIENT QUALIFIES FOR:** RWPB Medical Case Management _____ ADAP _____ RWPC Medical Case Management _____

## HOUSING STATUS

**Most Recent/Current Housing Status:**
□ Stable/ Permanently Housed □ Institution □ Unstable □ Temporary _____

## FINANCE INFORMATION

| | *(For state office use only)* |
|---|---|
| **Annual Gross Household Income:** _____<br>**Individual Annual Gross Income:** _____<br>**Household / Family Size: _____** | _____ Percent Poverty Level<br>□ Copy of Income Documentation<br>□ Copy of Photo Identification<br>□ Copy of Insurance Card (front and back) |

## INSURANCE INFORMATION

**Primary Insurance Type (may mark more than one):** □ No Insurance □ Private - Individual □ Private - Employer □ Medicare Part A/B □ Medicare Part D □ Medicare (Part unspecified) □ Medicaid □ VA, Other Military □ IHS □ Other (specify) _____

**Additional Insurance Questions:** Is insurance through the Health Insurance Exchange (ACA) □ Yes □ No

If you have insurance, what is the name of the of the insurance company and plan: _____

Does your health insurance cover medications? □ Yes □ No

If Y**es**, is there a total expense limit for medications? □ Yes □ No

If insurance is through previous employer, date COBRA Coverage began: _____/_____/_____

Have you applied for Medicaid? □ Yes □ No If **Yes**, Applied Date: ____/____/_____

Please indicate information has been gathered and shared by having client initial the appropriate box.

| ***Informational Forms (client provided copies and time for questions & answers):*** | ***Client's Initials*** |
|---|---|
| ***Client Rights and Responsibilities*** | |
| ***Complaint Grievance Procedures*** | |
| ***What You Need to Know About Idaho Laws on HIV*** | |
| ***Acknowledgement of Notice of Privacy Practices (agency specific)*** | |
| ***Other:*** | |

**Client Acknowledgement:**

As a partner in this process, I acknowledge that:

1) The above information is true to the best of my knowledge (_____).
2) The purpose of my participation in medical case management is to assure my engagement in HIV medical care (_____).
3) I will notify my medical case manager of any change in my health insurance status, financial situation, income, or living arrangements (_____).
4) I authorize this agency to share information and to coordinate care with the Ryan White Part B and Part C programs (_____).
5) This program involves the receipt of federal and/or state funds; any person supplying false information is subject to state and/or federal criminal prosecution, which may result in fines, imprisonment, or both. Additionally, there will be an automatic six month suspension from RWPB Programs and ADAP (_____).

_____ _____

Client/Guardian Signature Date

_____ _____

Medical Case Manager Signature Date